DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/24/12

10/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445369	A. BUILDING _____ B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND CARE & REHABILITATION CENTER	2750 EXECUTIVE PARK PLACE CLEVELAND, TN 37312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #30519, were completed on October 10, 2012, at Cleveland Care and Rehabilitation Center. No deficiencies were cited related to complaint investigatin #30519 under 42 CFR PART 482.13, Requirements for Long Term Care Facilities.	F 000	Disclaimer Statement Signature HealthCARE of Cleveland does not believe and does not admit that any deficiencies exist, before, during and after the survey. Signature HealthCARE of Cleveland reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceeding or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Signature HealthCARE of Cleveland reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this Plan of Correction should be considered as a waiver of any potential applicable Peer Review, Quality Assurance or self critical examination privileges which Signature HealthCARE of Cleveland does not waiver, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceedings. Signature HealthCARE of Cleveland offers its responses, credible allegations of compliance and plan of corrections as part of its ongoing efforts to provide quality of care to residents.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure the use of a chair alarm for one resident (#16) of sixteen current residents reviewed. The findings included: Resident #16 was admitted to the facility on July 6, 2011, with diagnoses including Pelvic Fracture, Weakness, Cardiac Dysrhythmia, Osteoarthritis, and Hypertension. Medical record review of the quarterly Minimum Data Set (MDS) dated August 2, 2012, revealed the resident required supervision for transfers and ambulation and had a history of falls.	F 323	F-232 1) Alarm for resident #16 was immediately placed in the resident's recliner by the Director of Nursing and Restorative Nursing Assistant. Certified Nursing Assistant was contacted and education was provided regarding personal alarm placement. 2) 100% audit was completed by the Restorative Nursing Assistant on residents whose care plan's indicated the use of personal alarms to ensure compliance with placement. This audit was completed on 10-22-12. Aberrances were corrected immediately	10-30-12 10-30-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10-24-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 Medical record review of a Fall Risk Evaluation dated August 8, 2012, revealed the resident had a total score of 24 (indicating high risk for falls). Medical record review of a falls Care Plan last updated on August 4, 2012, revealed "previous fall...intervention...bed & (and) chair alarm..." Observation on October 9, 2012, at 2:15 p.m., in the resident's room, revealed the resident sitting in a recliner without a chair alarm in place. Interview with the Director of Nursing (DON) on October 9, 2012, at 2:20 p.m., in the resident's room, confirmed the personal alarm was not in place.	F 323	3) The Staff Development Coordinator initiated education with the clinical staff regarding personal alarm placement on 10-9-12. Audit process was reviewed and revised to include Restorative Nursing Assistance checking placement weekly. Education with the Restorative Nursing Assistance was completed by the Restorative Nurse on 10-25-12 to the Restorative Nursing Assistants regarding new audit process. Aberrances will be corrected immediately 4) An audit log will be completed on residents with care plans indicating use of personal alarms for compliance with personal alarms weekly for four weeks. These audits will be done by Restorative Nursing Assistance to ensure compliance with personal alarm placement. Aberrances will be corrected immediately. These audit logs will continue monthly for three months. These audit logs will be reviewed quarterly by the QA committee to include the nurse managers the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinators, the Restorative Nurse Manager, Treatment Nurse, and Staff Development nurse, Administrator, Medical Director, Social Services and Activities Director for further recommendations.	10-30-12
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	F -431 1) Expired over the counter medication were immediately removed by LPN #1 and placed in the Director of Nursing office on 10-9-12. The expired over the counter medication were disposed of by the Director of Nursing, Intern and Pharmacist on 10-15-2012.	10-30-12

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F 431	Continued From page 2 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure expired medications were not available for resident use. The findings included: Observation of the medication room on October 9, 2012, at 10:15 a.m., revealed the following expired medications still on the shelf and available for resident use: 1. 2 bottles of 100 tablets each of Vitamin D 400 International Units, expiration date of July 2012. 2. 3 bottles of 100 gelcaps each of Vitamin E 400 International Units, expiration date of September 2012. 3. 3 bottles of 100 tablets each of Multivitamins with Iron, expiration date of March 2012.	F 431	2) 100% audit of all medication in the Medication room was completed by the Director of Nursing and Staff Development Coordinator on 10-9-12 to ensure no expired medications were available for use. 3) The Central supply coordinator was educated by the Director of Nursing regarding expired medication removal on 10-23-12. An audit log was developed by Administrator and Director of Nursing to audit medication in supply room and medication carts. This audit will be completed weekly by the Director of Nursing, Administrator and or the Central supply coordinator weekly to ensure that expired medications are not available for use. 4) The Director of Nursing, Administrator and /or the Central supply coordinator will complete audit weekly for four weeks. Aberrances will be corrected immediately. These audits will continue monthly for three months. These audit logs will be reviewed quarterly by the Quality Assurance Committee to include the Director of Nursing, the Assistant Director of Nursing, the MDS Coordinators, Restorative Nurse Manager, Treatment Nurse, Staff Development Coordinator, Administrator, Medical Director, Social Services and Activities Director for further recommendations.	10-30-12 10-30-12 10-30-12

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F 431	Continued From page 3 Interview with Licensed Practical Nurse (#1) on October 9, 2012, at 10:30 a.m., in the medication room; confirmed the medications were expired, were still on the shelf, and were still available for resident use.	F 431		